

Regence BlueCross BlueShield of Oregon 100 SW Market Street PO Box 1271 Portland, Oregon 97207-1271

## Waiver Form

am waiving coverage for the following reason(s). Check all that apply:   I do not wish to enroll myself and/or my dependent(s) in my group's medical plan at this time.   I currently have medical coverage elsewhere:     Carrier   Policy Number   Policy Type:  Group  Individual  Medicare  Medicaid  TriCare  Indian Health Service Government sponsored health plan  Other   I do not wish to enroll myself and/or my dependent(s) in my group's dental plan at this time. I do not wish to enroll myself and/or my dependent(s) in my group's dental plan at this time. I currently have dental coverage elsewhere: Carrier   Policy Type:   Government sponsored health plan   Other   I do not wish to enroll myself and/or my dependent(s) in my group's dental plan at this time. I currently have dental coverage elsewhere: Carrier   Policy Type:   Policy Type:   Group   Individual   Member ID Number   Policy Type:   Group   Individual   Medicare   Medicaid   TriCare   Indian Health Service   Government sponsored health plan   Other   Yppe:   Group   Individual   Medicaid   TriCare   Indian Health Service   Government sponsored health plan   Other   If you have checked the above for medical and/or dental coverage elsewhere but did not indicate the Carrier	SECTION 1 - GROUP INFORMATION									
Section 2 - EMPLOYEE INFORMATION       Social Security Number       Date of Birth         Name (Last, First, Middle)       Social Security Number       Date of Birth         Date of Hire       Average number of hours worked per week       Waiving coverage for: per week       Dependent(s)       Dependent(s)       Dependent(s)       Only         Section 3 - WAIVING COVERAGE INFORMATION       I have been offered coverage under my group's plan through Regence BlueCross BlueShield of Oregon (Regence), but an waiving coverage for the following reason(s). Check all that apply:       I do not wish to enroll myself and/or my dependent(s) in my group's medical plan at this time.       I currently have medical coverage elsewhere:         Carrier       Policy Number       Policy Number         Member ID Number										
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Date of Hire       Average number of hours worked per week       Waiving coverage for: [Employee/Dependent(s) ] Dependent(s) On!         SECTION 3 - WAIVING COVERACE INFORMATION       Image: Coverage inder my group's plan through Regence BlueCross BlueShield of Oregon (Regence), but an waiving coverage for the following reason(s). Check all that apply: [] I do not wish to enroll myself and/or my dependent(s) in my group's medical plan at this time. ] I currently have medical coverage elsewhere:         Carrier       Policy Number         Member ID Number       Policy Type: Group ] Individual ] Medicare ] Medicaid ] TriCare ] Indian Health Service [Government sponsored health plan ] Other         I currently have dental coverage elsewhere:       Carrier         Carrier       Policy Number         Member ID Number       Policy Type: Group ] Individual ] Medicare ] Medicaid ] TriCare ] Indian Health Service         Government sponsored health plan ] Other       Policy Number         Member ID Number       Policy Number         I type: Group ] Individual ] Medicare ] Medicaid ] TriCare ] Indian Health Service         Government sponsored health plan ] Other       Policy Number coverage elsewhere but did not indicate the Carrier         Member ID Number, please attach evidence of coverage. Evidence may be a copy of th previous month's billing, insurance ID card, or a curre										
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If you have checked the above for medical and/or dental coverage elsewhere but did not indicate the Carrier Policy Number or Member ID Number, please attach evidence of coverage. Evidence may be a copy of the previous month's billing, insurance ID card, or a current EOB (Explanation of Benefits). If you are waiving coverage under this medical/dental plan for yourself and/or your dependent(s) because of other healt insurance, you may be able to enroll yourself and your dependent(s) under this plan if you or your dependent(s) los eligibility for that other coverage or an employer stops contributing towards that other coverage provided that you request enrollment within 30 days after your other coverage ends. In addition, if you waive enrollment under this medical plan at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able	Policy Type: Group Individual Medicare Medicaid TriCare Indian Health Service									
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marriage, or within 60 days after the birth, adoption, or placement for adoption. Please contact your Group Administrator you require further information.	insurance, you may be able to enroll yourself and your of eligibility for that other coverage or an employer stops com- enrollment within 30 days after your other coverage ends. this time, and later acquire a new dependent due to marriage to enroll yourself and your dependent(s) under this plan, marriage, or within 60 days after the birth, adoption, or place	lependent(s) under the tributing towards that In addition, if you wa ge, birth, adoption, or provided that you rec	nis pla other ive e place quest	an if cov nroll emei enro	f you verag Imen nt fo ollmo	a or ye ge prov it unde r adop ent wi	our de vided er this tion, y thin 30	epend that y medi vou m 0 day	ent(s) rou re ical pl iay be s afte	lose quest an at able er the
I understand that I and/or any of my dependent(s) will be unable to obtain coverage under my group's health plan throug Regence until the next annual enrollment period, unless I and/or my dependent(s) qualify for a special enrollment period.										
I further certify that all information completed on this form is true, correct and complete and acknowledge that m coverage is subject to cancellation or other action permissible by law, if any completed information is found to be false c incorrect.	coverage is subject to cancellation or other action permissi									
Signature of Employee	Signature of Employee									
Signature of Employee Date						Da				